THE MILLMAN CLINIC

321 Los Gatos Saratoga Rd. ❁ Los Gatos, CA 95030 ❁ 408-218-9301
❁ DRKIM@THEMILLMANCLINIC.COM

PERSONAL INFORMATION PLEASE PRINT DATE_____

NAME_____REFERRED BY_____

ADDRESS_____CITY_____ STATE_____ZIP_____

HOME PHONE (_____)_____ WORK PHONE (_____)_____

MOBILE PHONE (_____)_____ EMAIL_____@_____

DATE OF BIRTH_____ AGE_____ SEX: M / F / TRANSGENDER

MARITAL STATUS: S M D W NAME OF SPOUSE/SIGNIFICANT OTHER _____

OCCUPATION _____ NUMBER OF CHILDREN IF ANY _____

NAME OF CHILD	AGE	SEX	ANY PHYSICAL CONDITIONS OR CONCERNS?
_____	_____	M / F	_____
_____	_____	M / F	_____
_____	_____	M / F	_____

HOUSEHOLD PETS IF ANY: _____

CURRENT HEALTH CONDITION

OVERALL HEATH (CIRCLE ONE): EXCELLENT / GOOD / FAIR / POOR / OTHER: _____

PRIMARY REASON YOU ARE HERE: _____

_____

TODAYS CONDITION STARTED WHEN? _____

WHAT ACTIVITIES AGGRAVATE YOUR CONDITION? _____

WHAT ACTIVITIES LESSEN YOUR CONDITION? _____

IS CONDITION WORSE DURING CERTAIN TIMES OF THE DAY? _____

IS THIS CONDITION INTERFERING WITH WORK? _____ SLEEP? _____ ROUTINE? _____

HOW IS YOUR CONDITION PROGRESSING (CIRCLE ONE): WORSE / BETTER / SAME

OTHER DOCTORS SEEN FOR THIS CONDITION_____

TYPE OF TREATMENT_____RESULTS_____

TYPE OF TREATMENT_____RESULTS_____

TYPE OF TREATMENT_____RESULTS_____

DRUG ALLERGIES _____

MEDICAL HISTORY

❑ Ringing In Ear_____
❑ Ear Infections - *Frequent* _____
❑ Dizziness/Fainting _____
❑ Failing Vision _____
❑ Eye Infections _____
❑ Nose Bleeds_____
❑ Sinus Trouble _____
❑ Sore Throats - *Frequent* _____
❑ Hayfever/Allergies _____
❑ Pneumonia _____
❑ Bronchitis/Chronic Cough_____
❑ Asthma/Wheezing _____
❑ Chest Pain _____
❑ High Blood Pressure _____
❑ Heart Murmur _____
❑ Swollen Ankles _____
❑ Leg Pain - *Walking*_____
❑ Varicose Veins/Phlebitis _____
❑ Loss of Appetite _____
❑ Difficulty Swallowing _____
❑ Indigestion or Heartburn _____
❑ Persistent Nausea/Vomiting _____
❑ Peptic Ulcers _____
❑ Abdominal Pain - *Chronic*_____

❑ Gall Bladder Trouble _____
❑ jaundice/Hepatitis _____
❑ Change in Bowel Habits _____
❑ Diarrhea ❑ Constipation _____
❑ Diverticulosis ❑ Crohn's/Colitis ____
❑ Bloody or Tarry Stools _____
❑ Hemorrhoids _____
❑ Hernia _____
❑ Urine Infections - *Frequent* _____
❑ Blood In Urine _____
Urination-❑ Overnight > than twice
❑ Painful ❑ Loss of Control
❑ Decrease in Force/Flow
❑ Kidney Stones _____
❑ Venereal Disease_____
❑ Urethral Discharge _____
❑ Chronic Fatigue _____
❑ Weight Loss - *Recent*_____
❑ Anemia ❑ Bruise Easily _____
❑ Cancer _____
❑ Diabetes _____
❑ Thyroid Disease _____
❑ Convulsions/Seizures _____
❑ Stroke _____

❑ Tremor/Hands Shaking _____
❑ Muscle Weakness _____
❑ Numbness/Tingling Sensations _____
❑ Headaches - *Frequent* _____
❑ Arthritis/Rheumatism _____
❑ Osteoporosis _____
❑ Back Pain - *Recurrent* _____
❑ Bone Fracture/Joint injury _____
❑ Gout _____
❑ Foot Pain ❑ Cold Numb Feet _____
❑ Rashes ❑ Hives _____
❑ Psoriasis ❑ Eczema_____
❑ Nervousness ❑ Depression_____
❑ Memory Loss _____
❑ Moodiness - *Excessive* _____
❑ Phobias _____
❑ Mental Illness_____
❑ Lactose Intolerance _____
❑ Prostate Disease _____
❑ Sexual/Menstrual Dysfunction ____
❑ Frequent Infections _____
❑ Diphtheria _____
❑ Tetanus _____
❑ Chicken Pox ❑ Polio ❑ Mumps ❑

Measles ❑ Rubella ❑ Rheumatic Fever
❑ Scarlet Fever ❑ Tuberculosis ❑ Herpes
❑ Other _____
❑ Other _____

Females - *Please Complete*
Pregnant? ❑ Yes ❑ No
Planning Pregnancy? ❑ Yes ❑ No
Menstrual Flow:
❑ Regular ❑ Irregular ❑ Pain/Cramps
____Days of Flow ____Length of Cycle
Date-1st day of last period_____
❑ Pain/Bleeding during or after sex
Number of:
____Pregnancies ____Abortions
____Miscarriages ____Live Births
Birth Control Method_____
B.C. Pill (Name) _____
❑ Flushing/Menopause
Date of Last PAP Test _____
❑ Normal ❑ Abnormal
Date of Last Mammogram
❑ Normal ❑ Abnormal

MEDICATIONS / SUPPLEMENTS

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

ACCIDENTS AND HOSPITALIZATIONS

Date	Reason	Date	Reason

HABITS / LIFESTYLE

- ❑ Alcohol: Type_____
  Amount_____
- ❑ Sleep:
  Difficulty falling asleep_____
  Difficulty staying asleep_____
- ❑ Daytime drowsiness_____
- ❑ Overall Stress:
  Low / Moderate / High
  Yoga/ Meditation /Other_____
  Vacations weeks per year _____
- ❑ Smoking: Packs daily_____
  How long_____
  Interested in stopping? _____
- ❑ Exercise: Y / N
  Frequency _____
  Type of Exercise_____
  _____
- ❑ Caffeine: Coffee, tea
  cups daily_____
- ❑ Sugar:
  Sodas: daily_____
  Cookies / candies / ice cream
  Artificial Sweeteners: Y / N
- ❑ Toxic Exposure:
  Eat Organic: Strictly/ mostly / rarely / no
  Farmer: Y / N
  Silver or Mercury Fillings: Y / N
  Filtered Water: Y / N
  Swim Often in Chlorinated Pool: Y / N
  Plastic Water Bottles: Y / N
  Mold Exposure: Y / N
  Heavy Chemicals: Y / N
  Painter: Y / N
  Dentist: Y / N
- ❑ Microbial Balance:
  Frequent Antibiotics: Y / N
  Breast Fed > 1 year: Y / N

DIET DIARY

PLEASE DESCRIBE YOUR TYPICAL DIET

BREAKFAST	LUNCH	DINNER

MORNING SNACK	AFTERNOON SNACK	EVENING SNACK

WATER /BEVERAGES	WATER /BEVERAGES	WATER /BEVERAGES

FOOD SENSITIVITIES

PLEASE LIST THE FOODS YOU ARE SENSITIVE TO, WHAT HAPPENS WHEN YOU EAT IT AND HOW OFTEN YOU EAT IT

	SENSITIVE?	IF YES, WHAT HAPPENS WHEN YOU EAT IT?	ARE YOU AVOIDING IT?
GLUTEN	☐	_____	☐ YES, STRICTLY ☐ LIMITING, BUT NOT STRICT ☐ NOT AVOIDING
DAIRY	☐	_____	☐ YES, STRICTLY ☐ LIMITING, BUT NOT STRICT ☐ NOT AVOIDING
EGGS	☐	_____	☐ YES, STRICTLY ☐ LIMITING, BUT NOT STRICT ☐ NOT AVOIDING
CORN	☐	_____	☐ YES, STRICTLY ☐ LIMITING, BUT NOT STRICT ☐ NOT AVOIDING
SUGAR	☐	_____	☐ YES, STRICTLY ☐ LIMITING, BUT NOT STRICT ☐ NOT AVOIDING
NUTS	☐	_____	☐ YES, STRICTLY ☐ LIMITING, BUT NOT STRICT ☐ NOT AVOIDING
BEANS	☐	_____	☐ YES, STRICTLY ☐ LIMITING, BUT NOT STRICT ☐ NOT AVOIDING
SOY	☐	_____	☐ YES, STRICTLY ☐ LIMITING, BUT NOT STRICT ☐ NOT AVOIDING
OTHER	☐	_____	☐ YES, STRICTLY ☐ LIMITING, BUT NOT STRICT ☐ NOT AVOIDING

FAMILY HISTORY

PLEASE GIVE THE FOLLOWING INFORMATION ABOUT YOUR IMMEDIATE FAMILY:

HAVE ANY BLOOD RELATIVES HAD THE FOLLOWING ILLNESSES? IF SO, PLEASE INDICATE RELATIONSHIP:

RELATIONSHIP	AGE IF LIVING	AGE AT DEATH	STATE OF HEALTH OR CAUSE OF DEATH	ILLNESS	FAMILY MEMBER
FATHER				DIABETES	
MOTHER				CANCER	
BROTHERS AND SISTERS	_____	_____	_____	BLOOD DISEASE	_____
	_____	_____	_____	GLAUCOMA	_____
	_____	_____	_____	EPILEPSY	_____
SPOUSE				RHEUMATOID ARTHRITIS	
CHILDREN	_____	_____	_____	TUBERCULOSIS	_____
	_____	_____	_____	GOUT	_____
	_____	_____	_____	HIGH BLOOD PRESSURE	_____
				HEART DISEASE	
				BACK PROBLEMS	